West Hills
BEHAVIORAL HEALTH HOSPITAL

West Hills Behavioral Health Hospital Closed on 12/20/2021
UHS-NRO now handles all Release of Information Requests.
Fax # 615-997-1200 Phone # 615-312-5834
1000 Health Park Dr. Bldg. 3 Ste. 400 Brentwood, TN 37027

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____ **Phone #:**_____
(Please print)

I authorize:	**To Release to:**
WEST HILLS HOSPITAL Name of Person or Entity	_____ Name of Person or Entity
1240 East Ninth Street Address	_____ Address
Reno, Nevada 89512 City	_____ City
Phone # Fax #	Phone # Fax #

To prevent delay of processing your request please include a copy of your government issued photo ID (i.e., a driver's license) for signature verification.

By marking the lines below, I signify that I consent for the following type(s) of information to be released to the above individual/entity.

___ Drug/Alcohol Abuse
___ HIV or AIDs related information
___ Psychiatric conditions
___ Medical conditions

Treatment Dates: _____

Information that may be released:

☐ **Industry Standard (Discharge Summary/Plan, Medication Reconciliation, H&P, Psych Eval, Labs)**
☐ **Medication Record**
☐ **History & Physical Exam**
☐ **Discharge Plan/Continuing Care Plan**
☐ **Psychiatric Evaluation**
☐ **Lab Results**
☐ **Discharge Summary**
☐ **Physician's Progress Notes**
☐ **Nursing/Therapy Notes**
☐ **Other (specify)** _____

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

___ Continuing Care ___ School ___ Disability benefits
___ Legal ___ Personal ___ Employment conditions

If for legal purposes, give specific reason: (must be completed)_____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

OTHER CONDITIONS:

This information has been disclosed to you from records whose confidentiality may be protected by Federal Law: "Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." [RM 203, 7.2] Rev. 4-12-04
This consent expires one year from the date below unless otherwise specified: (not to exceed one year) _____
Patients age 11 and younger require parent/guardian signature only; Patients age 12-17 require signature of both patient and parent/guardian; patients age 18 and older must sign exclusively unless there is a legal guardian.

_____

Signature of Patient **Date** **Signature of Parent/Guardian, if applicable**

Revocation: I hereby revoke the above authorization: Signature_____ ***Date***_____